Medical Memoranda

Full-term Abdominal Pregnancy with Survival of Mother and Child

The following is the history of this unusual case.

M. M., aged 31, para 1 in 1931, which was a normal delivery of a stillborn child of 8½ lb., came to the ante-natal clinic on June 30, 1941. She was in good health and her pregnancy apparently normal. Her last period was early in November, 1940, and the approximate date for delivery was the middle of August, 1941. Her external pelvic measurements were normal, the urine contained nothing abnormal, and her blood pressure was 135/65. The presentation was à transverse with the head in the right iliac fossa. She had no past history of any disease, pelvic pain, or menstrual disorder.

She was seen thrice at weekly intervals after her first visit, and each time the lie of the foetus was transverse with the head in the right iliac fossa. She was otherwise normal on these occasions. She was admitted to hospital on July 26, at 10.45 a.m., complaining of pain in the right iliac fossa. There was no history of a "show." On examining her I made the following observations:

Transverse lie, head to the right. Foetal heart sounds were heard and were normal. Vaginal examination revealed: (1) Cervix—external os patulous, internal os closed tightly. The cervix had not the soft feel of the normal cervix at the end of pregnancy. No placenta could be felt, but it seemed that there was a thick and hard part in the lower uterine segment—felt in the posterior fornix, and I thought it might be a fibroid tumour. (2) Diagonal conjugate 4 in.

An external version was then attempted, but it was found impossible to move the foetus, and pressure on the head increased the pain of which the patient already complained. She was thought not to be in labour as there were no abdominal contractions corresponding with the so-called labour pains. *X*-ray examination at this stage revealed one foetus, transverse lie, head to the right, dorsum down.

I decided to do a Caesarean section. A vertical subumbilical incision was made and the peritoneum was opened. The view then meeting the eye was that of a transparent sac in the abdomen filled with fluid—like a thin-walled ovarian cyst—in which the baby floated. The condition was then diagnosed as a full-term abdominal pregnancy, and Dr. Goodwin and Dr. Joseph, who were in the theatre block at that time, together with Dr. Burbidge, who was anaesthetizing the patient, were asked to watch the membranes being ruptured and the foetus being extracted. The child, a female, was alive and weighed 8 lb. 10 oz. The uterus was then sought, and it was the size of a 2½-months pregnancy. It was soft, and Hegar's sign was present. The left tube and ovary were normal, but some membrane was stuck to them. The outer half of the right tube and the ovary were continuous with the lower part of the placenta, which concealed it and the ovary from view.

The placenta was very large and thinned out like a placenta membranacea. It was adherent to small intestine, omentum, and transverse colon from below upwards, and its axis stretched from the right iliac fossa to the left hypochondriac region, where it was attached to the splenic flexure of the colon. A gentle attempt to pull off the upper part of the placenta at the splenic flexure started some haemorrhage. It was thought to be unlikely that the placenta could be separated from all its attachments without severe if not fatal haemorrhage, and it was decided to put a small gauze pack in the oozing area and to bring it through a drainage tube, leaving the placenta *in situ* after removing the redundant umbilical cord. The abdomen was then sutured in the usual way except that silkworm-gut sutures were used for the skin and 3 silkworm-gut retention sutures were used also. The tube and drain were sutured to the skin.

Immediate post-operative pulse rate was 140 per minute, and the volume was excellent. There was slight oozing through the tube drain. The gauze pack was removed next day, and after 48 hours the tube was withdrawn. A mild post-operative cough readily responded to treatment. On Aug. 2, the eighth day of convalescence, coincident with a rise in temperature, the lower half of the wound began to gape and ooze serum. The wound was treated with sulphanilamide powder and an elastoplast corset applied to the abdomen. On Aug. 4 a piece of tissue was passed per vaginam and was sent for microscopical examination. The pathological report on it read: "The specimen consists of two small fragments of soft greyish tissue. Microscopical examination: the tissue is almost entirely necrotic, but appears to consist of decidua in which there is a polymorphonuclear infiltration."

On Aug. 13 the baby developed a severe pemphigus and was transferred to an isolation hospital. On Aug. 15 a secondary suture was performed on the lower half of the wound. The elastic corset was reapplied. The wound healed slowly, and the patient and baby, now recovered from the pemphigus and apparently normal, were discharged from hospital on Oct. 9. During the convalescent stay in hospital the outline of the placenta could be seen on the surface of the abdomen and was noticed to diminish markedly, and on the patient's discharge from hospital it was half its original size.

On questioning the patient in retrospect one could elicit no history of past tubal infection, or of any pain whatsoever during pregnancy which might coincide with the time that a tubal pregnancy became abdominal, if such were the case.

At a follow-up consultation I saw the patient and her baby early in December, 1941, about 5 months after the operation. Then she was in excellent health and had no symptoms of any sort. The placental outline had diminished further and was now about the size of a sixteen-weeks pregnancy to the right of the middle line. It was causing no trouble. The baby was apparently normal in intelligence and had no physical flaw visible; she had bronchopneumonia soon after discharge from hospital and had been very ill with this, but had recovered well and was now gaining weight steadily.

I have looked up a number of cases in the literature, and have not found among these reports of a living baby weighing more than this child did at birth.

The salient features of this case are: (1) Absence of history of tubal infection or pain during the second month of pregnancy. These points tend to indicate that the pregnancy may have been a primary abdominal one. (2) Leaving the placenta *in situ* as it was adherent to intestine and omentum made the operation very simple and (*a*) caused no harm to the patient in the immediate post-operative phase, apart from the possibility that its weight may have caused the lower part of the skin wound to gape, or (*b*) caused no symptoms or ill effects in the five months following the operation.

Addendum.—The patient was readmitted to hospital on Jan. 15, 1942—six months after her operation—complaining of discharge from the wound. This was very profuse for the first week, during which the outline of the placenta diminished and finally disappeared. She was placed lying on her face for some hours daily to enable drainage to be complete, and at the end of four weeks the sinus had healed and closed over, and the outline of the placenta was no longer palpable. I saw the child at this stage and later at 8 months of age, and it was perfectly normal in every way.

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A Case of Klippel-Feil Syndrome

A woman aged 33 was admitted to the Herefordshire General Hospital with a fractured tibia and fibula—incidental to the case. Her appearance was typical of the Klippel-Feil syndrome, with that gnome-like facies. Her neck was very short and thick, measuring 18½ in. in circumference, and the head was set right on the shoulders. Her lateral movement was very limited. There was marked nystagmus, but no torticollis. She had a very low hair line, extending down between the upper margins of the scapulae. An operation had been performed on her neck at the age of 16 months, presumably for a meningocele. She still had a meningocele, about the size of half a hen's egg, in the midline just below the occiput.

X-ray examination showed that the bodies of the upper 6 cervical vertebrae were fused together, and that there was a joint between the sixth and seventh. There was also a spina bifida in the upper cervical region.

My thanks are due to Mr. C. L. Owen for allowing me to publish this case.

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L. E. Nolan and R. H. Jones (*Southern med. J.*, 1941, **34**, 1255), who record two illustrative cases in men aged 30 and 35 with a review of the literature, state that subcutaneous fibroid gummata in the neighbourhood of the elbows and knees constitute a little-known but important diagnostic sign and clinical manifestation of late syphilis. The lesions respond favourably to antisyphilitic treatment, while if untreated they may be disabling. Complement-fixation or precipitation tests for syphilis, and biopsy, are essential to the diagnosis.